THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-0240.M2

August 4, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1156-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board in orthopedic surgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 49 year-old male who sustained a work related injury on ___. The patient reported that while at work he was standing in a ditch when a boulder rolled down into the ditch hitting the patient in the ankles. The patient reported sustained bilateral talar fractures. The patient has undergone an MRI and CT scan of both ankles. On 4/1/01 the patient underwent a right ankle fusion. On 9/20/01 the patient underwent a left ankle fusion. On 11/9/01 the patient underwent a revision of the right fusion. The patient has been diagnosed with posttraumatic arthritis and status post ankle fusion, not completely fused or healed. The patient is also diagnosed with diabetic neuropathy.

Requested Services

Left below the knee amputation.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 49 year-old male who sustained a work related injury to his bilateral lower extremities on ___. The ___ physician reviewer also noted that the patient underwent a right ankle fusion on 4/1/01 and a left ankle fusion on 9/20/01. The ___ physician reviewer further noted that the patient underwent a revision of the right ankle fusion on 11/9/01. The ___ physician reviewer indicated that due to a non-fusion of the left ankle, a below the knee amputation has been requested. The ___ physician reviewer explained that the documentation provided does not show that the patient has undergone conservative treatment with orthotics and/or braces or demonstrated that the patient has a functional disability. The ___ physician reviewer indicated that the patient is also a diabetic who is suffering from neuropathy and that pain management documentation does not clearly indicate whether the patient is on analgesics and/or anti-inflamatories. The ___ physician reviewer also indicated that well outlined conservative programs including various alternatives have not been attempted. The ___ physician reviewer further indicated that current symptomatology and reasoning for why the below knee amputation is requested has not been documented in the chart sufficiently. Therefore, the ___ physician consultant has concluded that the requested left below the knee amputation is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 4th day of August 2003.